# Complete Summary

## GUIDELINE TITLE

Psychiatric/mental status evaluations in primary care settings. Mental health care for people with HIV infection.

## BIBLIOGRAPHIC SOURCE(S)

Psychiatric/mental status evaluations in primary care settings. In: Mental health care for people with HIV infection: HIV clinical guidelines for the primary care practitioner. New York (NY): New York State Department of Health; 2001 Mar. p. 13-8.

## GUIDELINE STATUS

This is the current release of the guideline.

## COMPLETE SUMMARY CONTENT



## SCOPE

### DISEASE/CONDITION(S)

- Human immunodeficiency virus (HIV) infection
- Mental health
- Depression and other psychiatric disorders associated with HIV
    - Mood disorders
    - Substance use disorders
    - Personality disorders
    - Adjustment disorders
    - Cognitive disorders
    - Suicide risk
    - Anxiety disorders

### GUIDELINE CATEGORY

Evaluation
Screening

## CLINICAL SPECIALTY

Allergy and Immunology
Family Practice
Infectious Diseases
Internal Medicine
Psychiatry

## INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Physician Assistants
Physicians
Public Health Departments

## GUIDELINE OBJECTIVE(S)

To develop guidelines for performing a complete psychiatric history and mental status examination (MSE) of patients with human immunodeficiency virus (HIV) infection in primary care settings

## TARGET POPULATION

Human immunodeficiency virus (HIV)-infected persons

## INTERVENTIONS AND PRACTICES CONSIDERED

1. Complete psychiatric history including
    - History of psychiatric disorders in patients and family (including number of hospitalizations and outpatient treatments)
    - History and efficacy of psychotropic medications
    - History of suicide or violence
    - History of education and occupational functioning
    - History of relationship functioning and family support
    - Legal history
    - Risk behavior history
2. Complete mental status examination including
    - General assessment of appearance, behavior, attitude, and speech
    - Assessment of insight and judgment about current illness and daily functioning
    - Assessment of mood, including suicidal/homicidal thoughts and ideation
    - Assessment of thoughts
    - Assessment of cognitive status
3. Repeated screening for psychiatric disorders at yearly intervals or more frequently if indicated

### MAJOR OUTCOMES CONSIDERED

Not stated

## METHODOLOGY

### METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

### NUMBER OF SOURCE DOCUMENTS

Not stated

### METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

### RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

### METHODS USED TO ANALYZE THE EVIDENCE

Review

### DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

### METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

### DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Human Immunodeficiency Virus (HIV) Guidelines Program works directly with committees composed of HIV Specialists to develop clinical practice guidelines. These specialists represent different disciplines associated with HIV care, including infectious diseases, family medicine, obstetrics and gynecology, among others.

Generally, committees meet in person 3 to 4 times per year, and otherwise conduct business through monthly conference calls.

Committees meet to determine priorities of content, review literature, and weigh evidence for a given topic. These discussions are followed by careful deliberation to craft recommendations that can guide HIV primary care practitioners in the delivery of HIV care. Decision making occurs by consensus. When sufficient evidence is unavailable to support a specific recommendation that addresses an important component of HIV care, the group relies on their collective best practice experience to develop the final statement. The text is then drafted by one member, reviewed and modified by the committee, edited by medical writers, and then submitted for peer review.

### RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

### COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

### METHOD OF GUIDELINE VALIDATION

Peer Review

### DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

#### General Recommendations

Because of the high prevalence of psychiatric problems in people with human immunodeficiency virus (HIV) infection, practitioners should perform a thorough baseline psychiatric evaluation, including history and complete mental status examination, for all HIV-infected patients, documenting their responses and the practitioners' assessments.

#### History and Examination

Elements of a Complete Psychiatric History of Patients with HIV

See the original guideline document for a list of elements to include in obtaining the patient's history.

Selected Elements of a Complete Mental Status Examination

The practitioner should use observation and questioning when conducting a general assessment.

General Assessment of Appearance and Behavior

The practitioner should observe the following: appearance, behavior, attitude, and speech (see the original guideline document for specific elements).

Assessment of Insight and Judgment About Current Illness and Daily Functioning

The practitioner should specifically assess the patient's insight and judgment related to his/her HIV infection. Does the patient show an adequate understanding of his or her illness and its treatment?

To ascertain whether the patient behaves in health-promoting ways, the practitioner should ask questions such as:

- Do you attempt to reduce risk of infecting others?
- Do you practice safe sex?
- Do you attempt to live in a healthy manner, eat well, rest, not use substances?
- Do you take medication as prescribed?

Assessment of Mood

General

To ascertain the patient's mood (e.g., sad, cheerful, anxious, irritable, labile), the practitioner should ask questions such as:

- Do you feel sad or depressed?
- Are you able to enjoy anything?
- Do you feel anxious or irritable?

Assessment of Suicidal and Homicidal Ideation

Practitioners should address and document any suicidal or homicidal thoughts, even though they may not necessitate emergency intervention. The decision of whether to institute emergency intervention should be determined by assessing the patient's level of intent and degree of control as well as the patient's ability to uphold a contract against the intention to harm self or others (refer to Figure 2-1 in the original guideline document for the sequence of questions to ask the patient for the assessment of suicidal/homicidal thoughts).

Practitioners should closely monitor patients who give answers indicating intention to harm themselves or others. If they have limited ability to control their intentions or to contract with practitioners against the intention, patients should immediately be referred for further psychiatric assessment and care.

Assessment of Thoughts

If the practitioner receives a positive response to any of the following questions regarding thought content, perception, and thought processes or observes that the patient seems to have a thought disorder, the practitioner should refer the patient not already under psychiatric care for further psychiatric evaluation and consider the need for psychotropic medication.

Thought Content

To ascertain whether the patient has delusions, the practitioner should ask questions such as:

- Have you ever felt that your thoughts were being controlled or broadcast out loud or that you could read other people's thoughts?
- Have you ever felt you were chosen for a special mission?
- Have you ever felt people were plotting against you?

Perception

To ascertain whether the patient has hallucinations, the practitioner should ask questions such as:

- Have you ever heard voices or seen or smelled things that other people did not?
- Have you ever received a message over the television or radio that was meant for you alone?

Thought Process

To ascertain whether the patient shows disorganized thought/language, the practitioner should not if the patient has:

- Overabundance or paucity of ideas
- Irrelevant or illogical thought processes

Assessment of Cognitive Status

Practitioners should perform and document follow-up evaluations of cognitive status on a yearly basis.

Practitioners should standardize their evaluation instruments to allow accurate comparison of baseline and subsequent evaluations.

Practitioners should choose one assessment instrument, use it for the initial evaluation, and, if possible, also use it for all subsequent evaluations. The choice of which instrument to use for assessment may not be as important as establishing a baseline status with one instrument and using the same instrument for subsequent examinations (see Appendix III in the "Companion Documents" field for examples of assessment instruments).

Practitioners should document the baseline cognitive function of patients because this baseline will serve as the best control for each patient over time.

### Monitoring

Practitioners should repeat cognitive assessment and screening for depression and other psychiatric disorders at yearly intervals or more frequently if there seems to be a change from baseline.

### CLINICAL ALGORITHM(S)

None provided

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

Appropriate psychiatric and mental status evaluation of human immunodeficiency virus (HIV)-infected patients in primary care settings

### POTENTIAL HARMS

Not stated

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

Following the development and dissemination of guidelines, the next crucial steps are adoption and implementation. Once practitioners become familiar with the content of guidelines, they can then consider how to change the ways in which they take care of their patients. This may involve changing systems that are part of the office or clinic in which they practice. Changes may be implemented rapidly, especially when clear outcomes have been demonstrated to result from the new practice such as prescribing new medication regimens. In other cases, such as diagnostic screening, or oral health delivery, however, barriers emerge which prevent effective implementation. Strategies to promote implementation, such as through quality of care monitoring or dissemination of best practices, are listed and illustrated in the companion document to the original guideline (HIV clinical practice guidelines, New York State Department of Health; 2003), which portrays New York's HIV Guidelines Program. The general implementation strategy is outlined below.

- Statement of purpose and goal to encourage adoption and implementation of guidelines into clinical practice by target audience.

- Define target audience (providers, consumers, support service providers).
    - Are there groups within this audience that need to be identified and approached with different strategies (e.g., HIV Specialists, family practitioners, minority providers, professional groups, rural-based providers)?
- Define implementation methods.
    - What are the best methods to reach these specific groups (e.g., performance measurement consumer materials, media, conferences)?
- Determine appropriate implementation processes.
    - What steps need to be taken to make these activities happen?
    - What necessary processes are internal to the organization (e.g., coordination with colleagues, monitoring of activities)?
    - What necessary processes are external to the organization (e.g., meetings with external groups, conferences)?
    - Are there opinion leaders that can be identified from the target audience that can champion the topic and influence opinion?
- Monitor progress.
    - What is the flow of activities associated with the implementation process and which can be tracked to monitor the process?
- Evaluate.
    - Did the processes and strategies work? Were the guidelines implemented?
    - What could be improved in future endeavors?

### IMPLEMENTATION TOOLS

#### Resources

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Living with Illness

### IOM DOMAIN

Effectiveness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

Psychiatric/mental status evaluations in primary care settings. In: Mental health care for people with HIV infection: HIV clinical guidelines for the primary care practitioner. New York (NY): New York State Department of Health; 2001 Mar. p. 13-8.

## ADAPTATION

Not applicable: The guideline was not adapted from another source.

## DATE RELEASED

2001 Mar

## GUIDELINE DEVELOPER(S)

New York State Department of Health - State/Local Government Agency [U.S.]

## SOURCE(S) OF FUNDING

New York State Department of Health

## GUIDELINE COMMITTEE

Mental Health Guidelines Committee

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## FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

## GUIDELINE STATUS

This is the current release of the guideline.

## GUIDELINE AVAILABILITY

Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.

Print copies: Available from Office of the Medical Director, AIDS Institute, New York State Department of Health, 5 Penn Plaza, New York, NY 10001; Telephone: (212) 268-6108

## AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- HIV clinical practice guidelines. New York (NY): New York State Department of Health; 2003. 36 p. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.
- Appendix I: interactions between HIV-related medications and psychotropic medications: indications and contraindications. New York (NY): New York State Department of Health; 2001 Mar. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.
- Appendix II: HIV-related causes of psychiatric symptoms: differential diagnosis. New York (NY): New York State Department of Health; 2001 Mar. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.
- Appendix III: rating scales. New York (NY): New York State Department of Health; 2001 Mar. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.

- Appendix IV: mental health care resources in New York State. New York (NY): New York State Department of Health; 2001 Mar. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.
- Appendix V: syringe access resources in New York State. New York (NY): New York State Department of Health; 2001 Mar. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.
- Appendix VI: permanency planning and transitional services. New York (NY): New York State Department of Health; 2001 Mar. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.

Print copies: Available from Office of the Medical Director, AIDS Institute, New York State Department of Health, 5 Penn Plaza, New York, NY 10001; Telephone: (212) 268-6108

### PATIENT RESOURCES

None available

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